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13. ABSTRACT (Maximum 200 words) The purpose of this study was to conduct a limited review of literature published between January 1986 and May 2001 concerning the accuracy and reliability of screening and diagnostic tests in polygraph, medicine, and psychology. Out of 5,189 hits produced by the literature search, 1,158 articles and abstracts were reviewed, 145 were found to be useful resulting in data on 198 studies. For field screening assessments, the sensitivity of polygraph, medical, and psychological tools was .59, .79, and .74 respectively. Specificity of polygraph, medical, and psychological tools was .92, .83, and .72. Agreement was measured with kappa. Among readers in polygraph, medicine, and psychology kappa was .77, .56, and .79 respectively. Reports in the literature of polygraph's accuracy and reliability (agreement) on specific issues appear to be consistent with published studies on medical and psychological assessment tools. However, there is an enormous range of accuracy and agreement not only within polygraph but also medicine and psychology. Although there were very few polygraph screening studies, accuracy reports were lower than those in medicine and psychology.			
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Comparative Analysis of Polygraph with Other
Screening and Diagnostic

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Project: *A Comparative Analysis of Polygraph with other Screening and Diagnostic Tools*

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Abstract

The purpose of this study was to conduct a limited review of literature published between January 1986 and May 2001 concerning the accuracy and reliability of screening and diagnostic tests in polygraph, medicine, and psychology. Out of the 5,189 hits produced by the literature search, 1,158 articles and abstracts were reviewed, 145 were found to be useful resulting in data on 198 studies. For field screening assessments, the sensitivity of polygraph, medical, and psychological tools was .59, .79, and .74 respectively. Specificity of polygraph, medical, and psychological screening was .90, .94, and .78. For field diagnostic assessments, the sensitivity of polygraph, medical, and psychological tools was .92, .83, and .72. Specificity of polygraph, medical, and psychological diagnostic testing was .83, .88, and .67 respectively. Agreement was measured with kappa. Among readers in polygraph, medicine, and psychology kappa was .77, .56, and .79 respectively. Reports in the literature of polygraph's accuracy and reliability (agreement) on specific issues appear to be consistent with published studies on medical and psychological assessment tools. However, there is an enormous range of accuracy and agreement not only within polygraph but also medicine and psychology. Although there were very few polygraph screening studies, accuracy reports were lower than those in medicine and psychology.

An Executive Summary is available on page 26 of this report.

Introduction

The purpose of this study was to conduct a limited review of the literature concerning the accuracy and reliability of screening and diagnostic tests in polygraph, medicine, and psychology. Measures in common use today for evaluating assessment tools assume perfection is the benchmark of a tool's efficacy. This inevitably causes disappointment in the performance of assessment tools, since they rarely produce 100% accuracy or reliability unless significant tradeoffs are made. The premise of this study is that something less than perfection is the common outcome of assessment tool studies. What follows is an effort to put the reported accuracy and reliability of polygraph in context with studies from the medical and psychological literature. It is important to recognize that comparing assessment tools across different disciplines and technologies will not clarify whether or not polygraph is an accurate or reliable means for detecting truth and deception. It does, however, place the less than perfect performance of polygraph along side other commonly used diagnostic and screening tools.

The literature review focuses on the validity (accuracy) and reliability (agreement) of polygraph as it compares to other assessment tools outside the framework of the detection of deception. The primary focus is on common medical (diagnostic radiology) assessment tools such as ultrasound (US), x-rays, computed tomography (CT), and magnetic resonance imaging (MRI) along with psychological assessment tools such as the Minnesota Multiphasic Personality Inventory (MMPI) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-III and IV). Polygraph's approach involves a human reader using technology to measure and interpret physiological conditions and responses to make a diagnosis. This process is very similar to the mechanics involved in diagnostic radiology. This connection between reader, technology, and examinee is less evident in the psychological literature where many of the assessment tools are

paper and pencil tests with established scoring systems that require no reader interpretation. An effort was made to locate assessment tools in education and personnel screening but few were found that either a) reported data that were comparable or b) were not already incorporated into the psychology literature.

A very utilitarian approach was used in gathering data for this comparative analysis. Study selection depended on whether there was sufficient information in an abstract to a) use in the analysis or b) would lead this investigator to believe usable data could be obtained from the article text. What follows is a very specific delineation of the methodology used. Consumers of this report should be warned that the summary measures calculated from this set of research studies may be different if another selection of studies is used.

Method

In addition to information provided by the Department of Defense Polygraph Institute (DoDPI) research staff, a literature search was conducted through MEDLINE of the National Library of Medicine, PsycInfo Direct of the American Psychological Association, and an index of polygraph studies on the National Polygraph Consultants website. The search was limited to research published in the past fifteen years, but some results from review articles include earlier studies. The keywords used in the literature search are listed in Table 1.

Table 1: Search Keywords

screening	multi-rater
screening test	test reliability
screening evaluation	personnel testing
screening techniques	security screening
screening accuracy	psychological testing
diagnostic	MMPI
diagnostic test	validity
diagnostic evaluation	accuracy
diagnostic techniques	sensitivity
diagnostic accuracy	specificity
reliability	area under the curve
agreement	receiver operating characteristic curve
kappa	ROC
percent agreement	test validity
rater agreement	

DoDPI staff provided assistance in collecting hard copy versions of polygraph articles and also gave guidance on relevant polygraph studies not found during the literature search. The polygraph studies were reviewed first to identify measures of accuracy and agreement that would be common to all three professions. Accuracy and agreement measures were reported in several

different forms and in several cases had to be converted to maintain consistency. Table 2 lists the common measures used for this review. These terms are more common in the medical literature but their meanings are directly transferable to polygraph and psychology.

Table 2: Summary of common terms used and not used in this study.

<u>Terms Used</u>	<u>Definition</u>	<u>Also Known As</u>
Sensitivity (Se)	The proportion of diseased cases with a positive test. (perfect accuracy = 1.0)	True Positive Rate (TPR)
Specificity (Sp)	The proportion of non-diseased cases with a negative test. (perfect accuracy = 1.0)	True Negative Rate (TNR)
Total Accuracy	$(Se+Sp)/2$ (perfect accuracy = 1.0)	Lykken's formula
Percent Agreement	The proportion of all readings conducted by two readers in which their interpretations agreed.	
Kappa (k)	Coefficient representing agreement obtained between two readers beyond chance. A value of 1 represents perfect agreement. A value of 0 represents no agreement.	
<u>Terms Not Used</u>	<u>Definition</u>	<u>Also Known As</u>
False Positive Rate	The proportion of non-diseased cases with a positive test. (perfect accuracy = 0.0)	1-Specificity
False Negative Rate	The proportion of diseased cases with a negative test. (perfect accuracy = 0.0)	1-Sensitivity
Total Accuracy	# of correct interpretations ÷ # of total interpretations	

The primary measures used in this report are sensitivity, specificity, and kappa. Sensitivity reflects the proportion of diseased cases correctly identified by an assessment tool. In polygraph, disease is analogous to deception. A sensitivity of 1.0 indicates the tool correctly identifies 100% of cases with the target condition. Specificity reflects the proportion of non-diseased (truthful) cases correctly identified by an assessment tool. A specificity of 1.0 indicates the tool correctly identifies 100% of cases without the target condition. Sensitivity and specificity are also averaged to give one combined estimate of accuracy. The combined accuracy measure is the same as that advocated by Lykken (1983) and used in a review of polygraph studies by McCauley and Forman (1988). The fourth measure is kappa. Kappa is a coefficient that represents agreement obtained between two readers beyond what would be expected by chance alone. A value of 1.0 represents perfect agreement. A value of 0.0 represents no agreement. Kappa can also range to -1.0 (perfect disagreement) but there are no negative kappas reported in this study. A list of common terms there are not used is also provided in Table 2.

Upon review, a study was categorized as either analog (laboratory) or field-based (actual cases) and whether they were measuring an assessment tool in a screening or diagnostic application. Screening applications involve the use of an assessment tool on a general population in which there is no specific evidence of disease. As an example, screening mammography is routinely used on asymptomatic women in the hope of finding disease at an early stage. Diagnostic correlates with the polygraph specific issue test and is reserved for studies where there is prior evidence a condition exists, such as when a test is ordered after a clinical examination of a patient suggests an abnormality. As an example, diagnostic

¹ Fleiss, J.L. (1981), *Statistical Methods for Rates and Proportions*. John Wiley, New York.
Landis, J.R and G.G. Koch. (1977). "The Measurement of Observer Agreement for Categorical Data." *Biometrics*

mammography is used on symptomatic women; those who have discovered a lump or other abnormality in the breast.

Abstracts were reviewed for evidence of comparable measures of accuracy and agreement. Exploratory studies, newsletters, commentaries, non-established scales, duplications, and studies that were unlikely to produce appropriate statistics were avoided. Agreement studies that didn't compare interpretations between two or more human raters were not used. If accuracy or agreement were reported separately by various control groups (sex, race, age) an effort was made to calculate an average. Scales that did not have an established cutoff for disease were not used. Only studies investigating a procedure in common use were used. This was determined by words and phrases in the text such as "preliminary," "could be used," "potential for." When accuracy was presented for both a newly proposed versus old established technique, only the data for the established technique were used. Studies involving the use of two or more procedures to form a decision and studies designed to stage the progression of known disease were also excluded. Medical studies involving invasive scopes were not used; nor did this review include any medical diagnostic tests outside radiology, such as pathology or cardiology. When accuracy was reported at several cutoffs, the first disease cutoff was used if there was no other indication of recommended practice. Contrary to the review conducted by the Office of Technology Assessment (OTA) in 1983, inconclusive results were not used in the accuracy estimates. Although inconclusives were rarely mentioned in the medical and psychological literature, when they were mentioned, they were explicitly excluded from the accuracy estimates. Inconclusive interpretations were used for agreement statistics when the data were available.

Data collected on accuracy, agreement, number of subjects, and number of studies were entered into a spreadsheet. These data were double-verified for accuracy. The spreadsheet was

used to sort studies and quantify summary measures. A mean, median, minimum, and maximum value were calculated to summarize the overall results of the screening and diagnostic studies found in this inquiry. This approach is similar to prior reviews. No statistical analysis was conducted nor is it recommended.

Weaknesses

Before continuing, the results of this review should be put into context by clearly noting several weaknesses in both study design and application. This report contains a fifteen-year snapshot of three literature domains, not definitive estimates of diagnostic test performance. Therefore the greatest concern is overgeneralization of the results beyond their simple intent to frame the science of accuracy and reliability. In addition, this review should be viewed with the following caveats in mind:

1. This is not a systematic review of the literature in polygraph, medicine, or psychology. Specific rules were followed to collect examples of the relevant body of literature, but there was also a very utilitarian perspective taken in obtaining a sampling of accuracy and agreement reports on commonly known assessment tools.
2. The summary statistics reported for polygraph, medicine, and psychology should not be interpreted as generalizable to all assessment tools or applications within these professions. The summary statistics are simply a method of conveying the central tendency and variation of accuracy and reliability estimates reported in the literature. They are not statements of accuracy for a particular procedure or profession. There is much more that would need to be done to develop that level of precision. As an example, a systematic and replicable review should include special analytical techniques such as

meta-analysis, study quality scoring, exclusion of low quality studies, and exhaustive disease-technology specific literature searches. This would be an enormous undertaking that far exceeds the objective of this study.

3. Similar to one of the weaknesses mentioned above, this review did not make any effort to determine the quality of the research that produced the statistics reported in the tables that follow.
4. It should be noted that the tools used for polygraph, medicine, and psychology are not directly comparable in either their technology, application, or patient populations.

Results

The results of this literature review are separated into several sections. After reviewing the results of the search effort, the overall results for screening and diagnostic accuracy will be presented. This will be followed by a rank-ordered comparison of accuracy as it relates to common medical and psychological diseases (e.g. appendicitis, depression). A rank-ordered comparison will also be provided by assessment technique (MRI, MMPI, etc.). The results section will conclude with a review of reader agreement.

Literature Search

A search for polygraph studies was conducted on April 1, 2001 through the index provided by National Polygraph Consultants (www.nationalpolygraphconsultants.com). Out of 152 articles found, 42 were reviewed, data from 16 articles were used representing 51 separate studies (see Table 3). A search for medical studies was conducted on April 30, 2001 through the PubMed index (www.ncbi.nlm.nih.gov/PubMed). The search looked for keywords in both the title and abstract and covered the time frame 1/1/1986 through 4/30/2001. Since there were tens of thousands of hits in PubMed, the search was refined to focus on any keywords in the title or abstract that contained both a common imaging modality (plain film, mammography, ultrasound, CT, MRI) and kappa, sensitivity, specificity, or receiver operating characteristic curve (ROC). Abstracts and/or articles from 933 articles were reviewed. Data from 90 of these articles were used representing 90 separate studies. A search for psychological literature was conducted via PsycInfo Direct (<http://www.psycinfo.com>) on April 29, 2001 for keywords in the abstract. The

search covered 1/1/1985 to 4/29/2001. Out of 3,975 articles found, 183 were reviewed, data from 39 articles were used representing 57 separate studies.

Table 3: Search Results

Field	Hits	Reviewed	Articles Used	Studies Reported
Polygraph	152	42	16	51
Medical	1,065	933	90	90
Psychological	3,975	183	39	57
Total	5,189	1,158	145	198

Although analog studies were very common in the polygraph literature, none were found in the psychology literature and only two were found in the medical literature. As a result, most comparisons mentioned in the report focus on describing field polygraph accuracy (bolded in tables); however, the tables also include results for analog polygraph along with analog and field studies averaged into one combined accuracy measure. Some articles reported more than one accuracy or agreement estimate. As a result, the count of studies provided in some of the tables may sum to more than what is reported in Table 3. A complete listing of the data used in this report is contained in the Appendix.

Accuracy of Screening Techniques

Five polygraph screening studies were found. Based on three analog studies, the mean sensitivity of polygraph screening (.76) is greater than that reported in the two field polygraph screening studies (.59). Specificity in analog polygraph screening studies (.82) is less than field

screening studies (.90). For ten medical screening studies, both the mean sensitivity (.79) and specificity (.94) are greater than polygraph. Psychology screening (36 studies) reports have greater sensitivity (.74) than polygraph but lower specificity (.78).

Table 4: Accuracy of screening techniques in polygraph, medicine, and psychology

		Polygraph			Medicine	Psychology
		Analog	Field	Combined*	Medicine	Psychology
Sensitivity (TPR)						
Mean	0.76	0.59	0.67		0.79	0.74
Median	0.67	0.59	0.63		0.78	0.79
Minimum	0.61	0.45	0.53		0.51	0.11
Maximum	1.00	0.73	0.86		0.97	1.00
Studies	3	2	5		10	36
Specificity (TNR)						
Mean	0.82	0.90	0.86		0.94	0.78
Median	0.83	0.90	0.87		0.93	0.85
Minimum	0.63	0.87	0.75		0.87	0.00
Maximum	1.00	0.93	0.97		1.00	1.00
Studies	3	2	5		10	36
Combined Accuracy						
Mean	0.79	0.74	0.77		0.86	0.76
Median	0.72	0.74	0.73		0.85	0.78
Minimum	0.65	0.69	0.67		0.76	0.42
Maximum	1.00	0.80	0.90		0.99	0.98
Studies	3	2	5		10	36
Number of Subjects						
Mean	50	467	258	56,581	996	
Median	40	467	253	19,758	307	
Minimum	40	200	120	79	55	
Maximum	71	733	402	202,070	16,235	
Studies	3	2	5	10	36	

* (analog + field)/2

Overall, the mean reported combined accuracy of screening polygraph (.74) is similar to screening psychology studies (.76) but lower than the mean combined screening accuracy for medical (.86) studies. The range between the minimum and maximum combined accuracy estimates from the literature is very different for polygraph (.69 to .80), medicine (.76 to .99), and psychology (.42 to .98). On average, polygraph screening studies use about half (467) as many subjects as psychology (996) studies and far less than reported for medical screening studies (56,581).

Accuracy of Diagnostic Techniques

There are 37 field polygraph, 94 medical, and 51 psychology diagnostic studies reported in Table 5. Mean sensitivity and specificity reported in field polygraph diagnostic studies are greater than those based on analog diagnostic studies. The mean sensitivity reported for medicine (.83) and psychology (.72) are lower than field polygraph (.92) studies. Although polygraph field studies have a mean specificity (.83) that is greater than psychology studies (.67), polygraph's specificity is similar but lower than that reported in the medical studies (.88). Overall, the mean combined diagnostic accuracy of polygraph (.88) and medical (.86) studies are very similar. The range between the minimum and maximum combined accuracy estimates from the literature are very similar for polygraph (.64 to 1.0), medicine (.60 to 1.0), and psychology (.50 to .93). On average, polygraph diagnostic studies use about half (108) as many subjects as medicine (284) and psychology (218).

Table 5: Accuracy of diagnostic techniques in polygraph, medicine, and psychology

	Polygraph			Medicine	Psychology
	Analog	Field	Combined		
Sensitivity (TPR)					
Mean	0.89	0.92	0.91	0.83	0.72
Median	0.92	0.95	0.94	0.85	0.71
Minimum	0.63	0.71	0.67	0.25	0.37
Maximum	1.00	1.00	1.00	1.00	0.96
Studies	18	37	55	94	51
Specificity (TNR)					
Mean	0.78	0.83	0.81	0.88	0.67
Median	0.79	0.90	0.85	0.93	0.65
Minimum	0.49	0.43	0.46	0.44	0.41
Maximum	0.97	1.00	0.99	1.00	0.95
Studies	18	37	55	94	51
Combined Accuracy					
Mean	0.84	0.88	0.86	0.86	0.70
Median	0.85	0.90	0.87	0.88	0.69
Minimum	0.60	0.64	0.62	0.60	0.50
Maximum	0.98	1.00	0.99	1.00	0.93
Studies	18	37	55	94	51
Number of Subjects					
Mean	72	108	90	284	218
Median	55	64	60	124	84
Minimum	15	16	16	23	29
Maximum	192	959	576	4,811	1,079
Studies	18	37	55	89	51

Accuracy by Target Condition

Table 6 reports screening and diagnostic accuracy by target condition and assessment technique used. The list is ordered from highest to lowest mean combined accuracy. Diagnosing acute appendicitis with computed tomography (CT) has the greatest combined accuracy (.96). Based on five studies, CT has a sensitivity of .95 and specificity of .98 in the diagnosis of acute appendicitis.

Table 6: Rank ordered "Combined Accuracy" on common medical & psychological diseases

<u>Target Condition</u>	Technique	Average Accuracy			Number of Studies
		Sensitivity (TPR)	Specificity (TNR)	Combined Accuracy	
Acute Appendicitis	CT	0.95	0.98	0.96	5
Brain Tumor	MRI	0.93	0.98	0.95	2
Carotid Artery Disease	US	0.89	0.93	0.91	14
Acute Appendicitis	US	0.84	0.97	0.91	2
Breast Cancer	US	0.92	0.87	0.90	3
Deception	Polygraph	0.92	0.83	0.88	37
Breast Cancer	MRI	0.98	0.74	0.86	3
Breast Cancer (screen)	Plain Film	0.79	0.92	0.86	4
Multiple Sclerosis	MRI	0.73	0.93	0.83	2
Breast Cancer	Plain Film	0.78	0.83	0.80	7
Alcohol Abuse (screen)	MAST*	0.80	0.78	0.79	4
Deception (screen)	Polygraph	0.59	0.90	0.74	2
Personality Disorders	DSM-IV**	0.84	0.60	0.72	3
Depression	MMPI	0.68	0.65	0.67	25

*Also included a study using MMPI

**Also included studies using ICD-10 and a Personality Index

Diagnosing depression with the MMPI has the lowest mean combined accuracy (.67) reported in Table 6. Based on 37 studies, diagnostic field polygraph studies have an average combined accuracy of .88. This is similar to using ultrasound to diagnose carotid artery disease (.91), acute appendicitis (.91), and breast cancer (.90). It is also similar to using MRI (.86) and plain film

(.86) to diagnose breast cancer. The combined accuracy of screening polygraph is one of the lowest reported in Table 6.

Accuracy by Evaluation Tool

Table 7 reports accuracy by type of evaluation tool. Similar to Table 6, the list is ordered from highest to lowest mean combined accuracy. Based on 37 field studies, diagnostic (specific issue) polygraph has the highest combined accuracy (.88). Overall, however, the combined diagnostic accuracy reported in field polygraph studies is very similar to those reported in MRI (.87), CT (.86), and ultrasound (.86) diagnostic studies. The MMPI, either screening (.61) or diagnostic (.67), has the lowest average combined accuracy.

Table 7: Rank ordered "Combined Accuracy" of diagnostic & screening tools

<u>Evaluation Tool</u>	<u>Average Accuracy</u>			
	Sensitivity (TPR)	Specificity (TNR)	Combined Accuracy	Number of Studies
Polygraph	0.92	0.83	0.88	37
MRI	0.86	0.88	0.87	17
CT	0.83	0.89	0.86	19
US	0.84	0.87	0.86	38
Plain Film	0.77	0.85	0.81	12
MAST (screening)	0.64	0.92	0.78	3
Polygraph (screening)	0.59	0.90	0.74	2
DSM-IV	0.72	0.68	0.70	1
MMPI	0.68	0.65	0.67	17
MMPI (screening)	0.70	0.53	0.61	5

Inter-Rater Agreement

Agreement among raters is measured as either the percent of cases in which two raters agree on an interpretation or the proportion of agreement beyond that expected by chance, which is represented by the kappa coefficient. Although these are very common measures of agreement, neither of these measures were reported often in the literature reviewed for this study. As an example, there was only one study gathered in the search of psychology literature that reported between rater percent agreement. All agreement studies reported in Table 8 are based on field studies. There were only three screening studies found that reported agreement data and these were all polygraph. There were no analog studies found.

The eight polygraph studies reporting percent agreement averaged 91% among polygraph examiners compared to 81% for physicians (based on five studies). Kappa coefficients were found in all three disciplines. Based on six studies in the psychology literature, the mean kappa among psychologists is .79. This is similar to polygraph examiners (.77) but greater than reports on physicians (.56). It is important to note that kappa is a chance corrected measure. This means that the kappa coefficient depends on both agreement and the distribution of cases used in a particular study. Two studies with identical percent agreements can have dramatically different kappas if the distribution of subject diagnoses vary (proportion of subjects with and without disease). As a result, it is very difficult to compare kappa from one study to the next either within the same discipline or between two disciplines.

Table 8: Inter-rater agreement on diagnostic cases among polygraph examiners, physicians, and psychologists

	Polygraph Examiners	Physicians	Psychologists
Percent Agree			
Mean	91%	81%	88%
Median	91%	80%	88%
Minimum	77%	77%	88%
Maximum	100%	85%	88%
Studies	8	5	1
Kappa (bi-rater)			
Mean	0.77	0.56	0.79
Median	0.80	0.60	0.79
Minimum	0.53	0.34	0.64
Maximum	1.00	0.72	0.91
Studies	9	13	6
Number of Subjects			
Mean	102	150	174
Median	69	138	113
Minimum	21	41	76
Maximum	402	308	331
Studies	9	14	6

Conclusion

The purpose of this study was to conduct a limited review and analysis of the literature concerning the accuracy and reliability of screening and diagnostic tests in polygraph, medicine, and psychology. Out of the 5,189 hits produced by the literature search, 1,158 articles and abstracts were reviewed, 145 were found to be useful resulting in data on 198 studies. The results of this review have shown there is an enormous range in reports of accuracy and agreement not only in polygraph but also medicine (limited to diagnostic radiology) and psychology. Overall, polygraph research on specific issue tests reports accuracy results similar to medicine. In contrast, polygraph screening studies report lower accuracy than medical studies but are similar to what is reported in the psychology literature.

To put these results into perspective, it's worth reviewing several methodological issues raised almost two decades ago in the Office of Technology Assessment's (OTA) report on the "Scientific Validity of Polygraph Testing." These issues, taken directly from the Conclusion of the OTA report, are as follows:

- Accuracy is affected by factors such as reader training, experience, personal bias, and examinee characteristics
- Cases and readers are often selectively chosen rather than randomly
- Criteria for ground truth are inadequate in some studies
- There is wide variability in results from multiple studies

This review found that these same methodological deficits are very evident in the medical and psychological literature. Polemics on polygraph often correctly identify these issues but either

overstate or fail to mention that these same problems afflict much of the research in medicine and psychology.²

To put the results of this review in context, Table 9 contrasts the average accuracy found in field diagnostic studies with those reported in the OTA study in 1983. Since the OTA study included inconclusive results in accuracy estimates (and this study does not), it is not surprising that this current literature review reports a somewhat greater level of accuracy. As can be seen, however, the level of polygraph accuracy found by OTA is in the same " ballpark" as that reported in medicine and psychology.

Table 9: OTA findings compared to study results (field diagnostic cases)

Aggregate Measures	<u>Average Accuracy</u>				Number of Studies
	Sensitivity (TPR)	Specificity (TNR)	Combined Accuracy		
OTA Findings (w/Incl.)	.86	.76	.81		10
Current Polygraph Findings	.92	.83	.88		37
Medicine	.83	.88	.86		94
Psychology	.72	.67	.70		51

The findings presented in Table 9 are consistent with OTA's conclusion that research into specific issue polygraph testing has shown the technique has some validity. It does not, however, answer the question of polygraph validity in screening tests. Although not very extensive, this review reports three analog and two field screening polygraph studies. Table 10 puts these alongside what was found for medical and psychological screening. As can be seen, the mean combined accuracy of medical screening (.86) is greater than the mean reported for analog or field polygraph screening studies. Both field (.74) and analog (.79) polygraph studies

² For a recent example, see Aftergood, Steven. "Polygraph testing and the DOE National Laboratories." SCIENCE

are similar to psychology screening studies (.76), but the reported sensitivity of field (.59) polygraph screening is noticeably lower than the mean found for medical and psychological screening.

Table 10: Rank ordered findings for screening studies

Aggregate Measures	Average Accuracy				Number of Studies
	Sensitivity (TPR)	Specificity (TNR)	Combined Accuracy		
Medicine (Field)	.79	.94	.86		10
Current Polygraph Findings (Analog)	.76	.82	.79		3
Psychology (Field)	.74	.78	.76		36
Current Polygraph Findings (Field)	.59	.90	.74		2

Summary

There has been much debate over the past 30 years about polygraph and its accuracy, reliability, utility, and lack of theoretical foundation. It should be recognized from this literature review, however, that many of these same issues could be raised about medical and psychological diagnostic tools. Based on the results of this review, it is unlikely polygraph research will be able to reach a level of accuracy and reliability to satisfy its opponents. It suffers from the same flaws of many other diagnostic tools: it will not be 100% accurate, nor will its application from one subject to the next or by one examiner to another be invariant.

The accuracy of humans assessing humans is unlikely to be 100%. As has been shown in this brief survey of the medical and psychological literature, there is wide variation in the accuracy of diagnostic tools from one application to the next. In fact, there is often wide

variation between studies focused on one diagnostic tool, such as has been seen in past polygraph reviews. Since perfection remains elusive, some professions have learned to accept and manage this uncertainty. As an example, training, standardization, and an ongoing review of procedures are used to establish a baseline of acceptable practice and alternative mechanisms are developed and employed to help clarify equivocal test results.

Recommendations

One of the goals of this study is to compare polygraph research methodology to that used in medicine (diagnostic radiology) and psychology. The author does not claim to be an expert in all these methodologies, so what follows are general impressions from the literature review and personal experience.

1. *Room for the "Medical" Perspective?* Most research found in the medical profession uses very specific terminology (sensitivity, specificity, odds ratios) and other methodological approaches (receiver operating characteristic curves) for assessing diagnostic tests. Greater use of similar terminologies and methodological approaches in polygraph may make the results of polygraph research more meaningful to those outside the polygraph and psychology community. There may also be a reservoir of methodologies and knowledge in the health technology assessment field that could be applied to polygraph research.
2. *Greater Focus on Accuracy and Reliability?* The polygraph literature reviewed for this study occasionally delved more into providing a sophisticated analysis of process and metrics instead of clarifying how the outcomes of these factors affect accuracy and reliability. In

several cases, basic measures of accuracy or reliability were not immediately apparent (sensitivity, specificity, and kappa had to be hand calculated from frequencies in tables).

3. *Analog Generalizability?* Although analog studies are practically nonexistent in the medical and psychological literature, they appear to serve an important role in polygraph research and are very valuable in assessing the internal validity of a test. It is difficult, however, to see how analog studies are generalizable to an applied (clinical) setting. As with medical and psychological tools, its unlikely polygraph will be able to demonstrate efficacy with a heavy reliance on laboratory studies.
4. *Screening Studies?* Compared to the number of specific issue polygraph studies, there were relatively few screening studies available for review. Although developing a suitable gold standard (ground truth) for an evaluation of field polygraph screening is a very difficult problem to surmount, similar issues have been faced by medicine and psychology. Based on the medical and psychological literature, there appears to be a considerable range in the quality of gold standards. The point suggested from the literature is that lack of a "pure" gold standard has not stopped screening research in psychology and medicine.
5. *Too Many Inconclusives?* Although inconclusive test results were a common element in polygraph research, they were seldom mentioned in the medical and psychological literature. Any accuracy or reliability study which selects out only obvious interpretations will inflate accuracy estimates and threatens both the legitimacy of the research and the assessment technique.

Executive Summary

Executive Summary

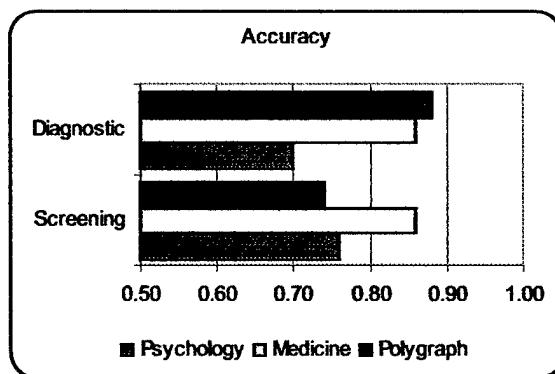
A Comparative Analysis of Polygraph with other Screening and Diagnostic Tools

Method

A limited review of literature published between January 1986 and May 2001 was conducted to evaluate studies reporting the accuracy and reliability of screening and diagnostic tests in polygraph, medicine, and psychology. Data for 198 studies were collected from 145 articles. Accuracy estimates are the combined average of sensitivity and specificity across all studies found within a particular category (1.00 = 100% accuracy).

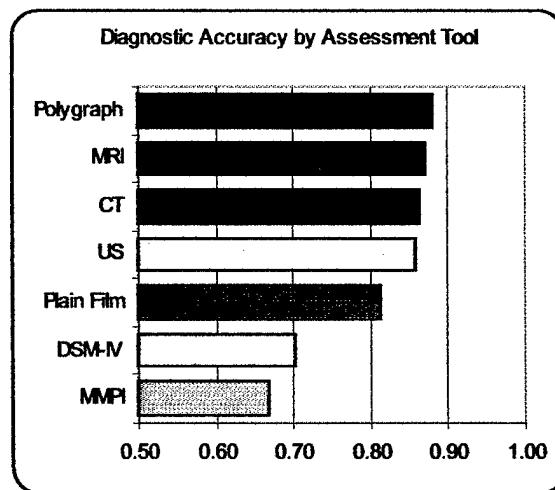
Diagnostic and Screening Accuracy

For field diagnostic assessments, the accuracy of polygraph, medical, and psychological tools was .88, .86, and .70 respectively. For field screening assessments, the accuracy of polygraph, medical, and psychological tools was .74, .86, and .76 respectively.



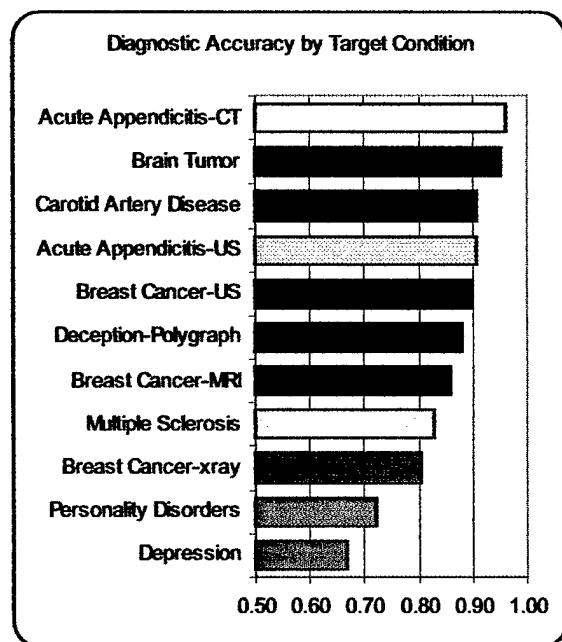
Accuracy of Various Diagnostic Tools

The average accuracy reported for 37 diagnostic polygraph studies (specific issue) was similar to MRI (17 studies), CT (19 studies), and ultrasound (38 studies). MMPI had the lowest reported accuracy (17 studies).



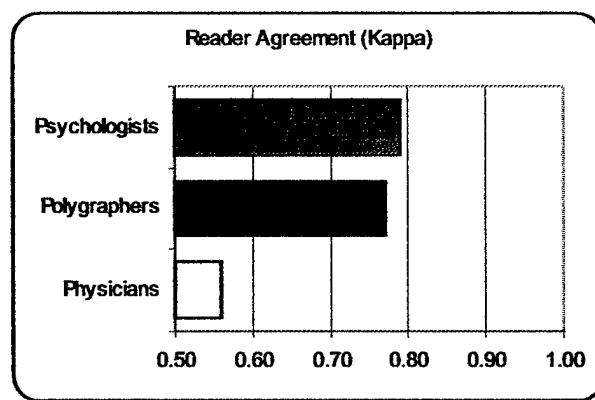
Accuracy by Target Condition

The average diagnostic accuracy for detecting deception with polygraph was similar to diagnosing breast cancer with MRI or ultrasound (US).



Agreement (kappa)

Averaging a standard measure of agreement across the reviewed literature suggests polygraph and psychology studies report similar levels of agreement. A kappa value of 1.0 represents 100% agreement beyond what would be expected by chance.



Conclusion

The level of accuracy and agreement reported in the polygraph literature is consistent with the medical and psychological literature.

Data Tables

Polygraph Studies

Field Accuracy Studies								
	Screening				Diagnostic			
	Se	Sp	Total %	Cases	Se	Sp	Total %	Cases
Mean	0.59	0.90	0.74	467	0.92	0.83	0.88	108
Median	0.59	0.90	0.74	467	0.95	0.90	0.90	64
Minimum	0.45	0.87	0.69	200	0.71	0.43	0.64	16
Maximum	0.73	0.93	0.80	733	1	1	1	959
Count	2	2	2	2	37	37	37	37
First Author	Year							
Jayne-screening	1989	0.45	0.93	0.69	200			
Brownlie	1997	0.73	0.87	0.80	733			
Bersh-GQT	1969					0.97	0.89	0.93
Bersh-GQT &ZOC majority	1969					0.71	0.80	0.76
Bersh-GQT and ZOC	1969					0.93	0.92	0.93
Bersh-ZOC	1969					0.89	0.94	0.92
Horvath	1971					0.85	0.91	0.88
Hunter	1973					0.88	0.86	0.87
Slowick	1975					0.85	0.93	0.89
Wicklander	1975					0.95	0.93	0.94
Barland-judicial	1976					1.00	0.43	0.72
Barland-panel	1976					0.98	0.45	0.72
Raskin-nonnumerical	1976					0.93	0.69	0.81
Raskin-numerical	1976					1.00	0.95	0.98
Horvath	1977					0.77	0.51	0.64
Davidson	1979					0.88	0.81	0.85
Yamamura & Miyake	1980					0.80	0.94	0.87
Edwards	1981					0.98	0.98	0.98
Kleinmuntz	1982					0.75	0.63	0.69
Putnam	1983					0.99	0.95	0.97
Elaad-blind	1985					0.77	0.77	0.77
Elaad-blind	1985					0.77	0.90	0.84
Elaad & Schahar	1985					0.99	0.95	0.97
Yankee-Experienced examiners-without incl	1985					1.00	0.99	1.00
Yankee-Inexperienced examiners-without incl	1985					1.00	0.99	1.00
Patrick	1987					1.00	0.90	0.95
Patrick-blind	1987					0.98	0.55	0.77
Honts & Driscoll-ranked scores	1988					0.94	0.65	0.80
Honts & Driscoll-std num scores	1988					0.97	0.77	0.87
Honts-blind	1988					1.00	0.80	0.90
Raskin	1988					0.95	0.96	0.96
Raskin-blind	1988					0.94	0.86	0.90
Franz-blind	1989					1.00	0.97	0.99
Matte-blind	1989					1.00	1.00	1.00
Murray	1989					1.00	0.86	0.93
Arellano-blind	1990					1.00	1.00	1.00
Patrick & Iacono	1991					0.97	0.56	0.77
Krapohl et al-specific issue	2001					0.87	0.92	0.90
Krapohl et al-specific issue	2001					0.84	0.97	0.91

Polygraph Studies

	Analog Accuracy Studies							
	Screening				Diagnostic			
	Se	Sp	Total %	Cases	Se	Sp	Total %	Cases
Mean	0.76	0.82	0.79	50	0.89	0.78	0.84	72
Median	0.67	0.83	0.72	40	0.92	0.79	0.85	55
Minimum	0.61	0.63	0.65	40	0.63	0.49	0.60	15
Maximum	1.00	1.00	1.00	71	1.00	0.97	0.98	192
Count	3	3	3	3	18	18	18	18

First Author	Year	Se	Sp	Total %	Cases	Se	Sp	Total %	Cases
Correa & Adams-preemployment	1981	1.00	1.00	1.00	40				
Ansley-screening	1989	0.61	0.83	0.72	71				
Honts	1999	0.67	0.63	0.65	40				
Barland	1975					0.83	0.71	0.77	72
Podlesny	1978					0.81	0.96	0.89	40
Raskin	1978					1.00	0.95	0.98	48
Rovner	1978					0.90	0.85	0.88	72
Dawson	1980					1.00	0.70	0.85	24
Hammond	1980					0.96	0.67	0.82	62
Bradley-electrodermal	1981					0.82	0.86	0.84	192
Bradley-heart rate	1981					0.63	0.63	0.63	192
Szecko	1981					0.71	0.49	0.60	30
Ginton	1982					1.00	0.85	0.93	15
Honts	1982					1.00	0.67	0.84	21
Honts	1982					1.00	0.67	0.84	38
Kischer	1983					0.94	0.97	0.96	100
Honts & Driscoll-ranked scores	1987					0.95	0.86	0.91	41
Honts & Driscoll-std num scores	1987					0.86	0.86	0.86	44
Barland et al-multiple issue approach	1990					0.93	0.75	0.84	100
Barland et al-single issue approach	1990					0.91	0.83	0.87	100
Blackwell-Examiners	1996					0.86	0.73	0.79	108

Polygraph Studies

Field Agreement Studies						
	Screening			Diagnostic		
	Agree %	Kappa	Cases	Agree %	Kappa	Cases
Mean	0.98		53	0.91	0.77	102
Median	0.99		60	0.91	0.80	69
Minimum	0.95		40	0.77	0.53	21
Maximum	0.99		60	1.00	1.00	402
Count	3	0	3	8	9	9

First Author	Year	Agree %	Kappa	Cases	Agree %	Kappa	Cases
Edel & Moore	1984	0.95		40			
Yankee-Experienced examiners-with incl	1985	0.99		60			
Yankee-Inexperienced examiners-with incl	1985	0.99		60			
Elaad	1985				0.77	0.53	60
Elaad	1985				0.83	0.67	60
Patrick	1987				0.86	0.60	69
Honts	1988				0.90	0.81	21
Raskin	1988				0.91	0.80	70
Franz	1989				0.99	0.98	81
Matte	1989				1.00	1.00	114
Arellano	1990				1.00	1.00	40
Patrick & Iacono	1991					0.53	402

Medical Studies

	Field Accuracy Studies							
	Screening				Diagnostic			
	Se	Sp	Total %	Cases	Se	Sp	Total %	Cases
Mean	0.79	0.94	0.86	56581	0.83	0.88	0.86	284
Median	0.78	0.93	0.85	19758	0.85	0.93	0.88	124
Minimum	0.51	0.87	0.76	79	0.25	0.44	0.60	23
Maximum	0.97	1.00	0.99	202070	1.00	1.00	1.00	4811
Count	10	10	10	10	94	94	94	89

First Author	Tech	Year	Se	Sp	Total %	Cases	Se	Sp	Total %	Cases
Baines-breast cancer	Mammography	1988	0.75	0.94	0.85	44718				
Unk author-breast cancer	Mammography	1992	0.91	0.96	0.94	72706				
Burhenne-breast cancer	Mammography	1995	0.84	0.93	0.88	201937				
Beam-breast cancer	Mammography	1996	0.79	0.90	0.85	79				
Heinzen-breast cancer	Mammography	2000	0.78	0.92	0.85	202070				
Mettlin-prostate cancer	US	1991	0.77	0.89	0.83	2425				
Levi-congenital anomalies	US	1995	0.51	1.00	0.76	25046				
Strandell-endometrial pathology	US	1999	0.73	0.87	0.80	103				
Lennon-neural tube and ventral wall defects	US	1999	0.97	1.00	0.99	2257				
van Nagell-ovarian cancer	US	2000	0.81	0.99	0.90	14469				
Stark-Hepatic metastases	CT	1987					0.80	0.94	0.87	135
Shackford-minor head injuries	CT	1992					1.00	0.51	0.76	2166
Pasanen-unjaundiced cholestasis	CT	1994					0.53	0.86	0.70	33
van Gils-paraganglioma of the head/neck	CT	1994					0.73	0.94	0.84	60
Budoff-coronary artery disease	CT	1996					0.95	0.44	0.70	710
Rao- appendicitis	CT	1997					0.98	0.98	0.98	100
Mushlin-multiple sclerosis	CT	1997					0.25	0.95	0.60	303
Mushlin-brain tumor	CT	1997					0.93	1.00	0.97	303
Mushlin-cerebrovascular disease	CT	1997					0.88	0.95	0.92	303
D'Ippolito- appendicitis	CT	1998					0.91	1.00	0.96	52
Miller-acute flank pain	CT	1998					0.96	1.00	0.98	106
Vieweg- acute flank pain	CT	1998					0.98	0.98	0.98	105
Keberle- throat tumors	CT	1999					0.88	1.00	0.94	99
Lane- appendicitis	CT	1999					0.96	0.99	0.98	300
Garcia - appendicitis	CT	1999					0.94	0.94	0.94	139
Valk-colorectal cancer	CT	1999					0.69	0.96	0.83	115
Kurtz-ovarian cancer	CT	1999					0.92	0.89	0.91	213
Walker- appendicitis	CT	2000					0.94	1.00	0.97	65
Joseph-open-globe injuries	CT	2000					0.75	0.93	0.84	200
von Kummer-stroke damage	CT	2001					0.64	0.85	0.75	786
Stafford-blunt abdominal trauma	CT no contrast	1999					0.89	0.57	0.73	195
Stafford-blunt abdominal trauma	CT with contrast	1999					0.84	0.94	0.89	199
Martelli-breast cancer	Mammography	1990					0.73	0.80	0.77	1708
Elmore-breast cancer	Mammography	1994					0.70	0.94	0.82	150
Cwikla-breast cancer	Mammography	1998					0.70	0.57	0.64	70
Fenlon-breast cancer	Mammography	1998					0.81	0.82	0.82	44
Drew-breast cancer	Mammography	1999					0.88	0.89	0.88	285
Zonderland-breast cancer	Mammography	1999					0.83	0.97	0.90	4811
Moss-breast cancer	Mammography	1999					0.79	0.83	0.81	559
Stark-Hepatic metastases	MR	1987					0.82	0.99	0.91	135
Barronian-imaging of the knee	MR	1989					0.67	0.86	0.77	23
Glasgow-anterior cruciate and meniscal lesions	MR	1989					0.83	0.84	0.84	47
Mooney-multiple sclerosis	MR	1990					0.88	0.94	0.91	
Mooney-brain infarct	MR	1990					0.88	1.00	0.94	
Mooney-brain tumor	MR	1990					0.93	0.95	0.94	
Mooney-other brain disease	MR	1990					0.91	0.92	0.92	
Young-carotid artery stenosis	MR	1994					0.89	0.82	0.86	70
Levine-osteomyelitis	MR	1994					0.77	1.00	0.89	26
Ascher-Endometriosis	MR	1995					0.76	0.60	0.68	31
Mussurakis-breast cancer	MR	1996					0.99	0.56	0.78	57
Mushlin-multiple sclerosis	MR	1997					0.58	0.91	0.75	303
Mushlin-brain tumor	MR	1997					0.93	1.00	0.97	303
Mushlin-cerebrovascular disease	MR	1997					1.00	1.00	1.00	303
Regan-acute cholecystitis	MR	1998					0.91	0.79	0.85	72
Kurtz-ovarian cancer	MR	1999					0.98	0.88	0.93	280
Drew-breast lesions	MR	1999					0.99	0.91	0.95	285
Blanchard-rotator cuff tears	MR	1999					0.79	0.81	0.80	38
Razumovsky-acute cerebral ischemia	MR	1999					0.84	1.00	0.92	30
Adamek-pancreatic cancer	MR	2000					0.84	0.97	0.91	124
Schröter-Creutzfeldt-Jakob disease	MR	2000					0.67	0.93	0.80	220
Imbriaco- breast masses	MR	2001					0.96	0.75	0.86	49
Scott-orthopedic fractures	PLAIN FILM	1993					0.79	0.83	0.81	60

Medical Studies

Analog Accuracy Studies								
	Screening				Diagnostic			
	Se	Sp	Total %	Cases	Se	Sp	Total %	Cases
	Mean				0.81	0.73	0.77	92
	Median				0.81	0.73	0.77	92
	Minimum				0.79	0.59	0.71	80
	Maximum				0.83	0.86	0.83	104
	Count	0	0	0	0	2	2	2

First Author	Tech	Year					
Hill-foreign bodies in human tissue	US	1997					
Orlinsky-radiolucent foreign body	US	2000					

Medical Studies

Field Agreement Studies						
	Screening			Diagnostic		
	Agree %	Kappa	Cases	Agree %	Kappa	Cases
	Mean			0.81	0.56	150
	Median			0.80	0.60	138
	Minimum			0.77	0.34	41
	Maximum			0.85	0.72	308
	Count	0	0	0	5	13

First Author	Tech	Year			
Freed-ureteral stone disease	CT	1998			
Grotta-stroke	CT	1999		0.69	103
Weishaupt -osteoarthritis	CT	1999	0.77	0.39	70
Kurtz-ovarian cancer	CT	1999		0.60	308
Elmore-breast cancer	Mammography	1994		0.65	213
Baker-breast cancer	Mammography	1996	0.78	0.47	150
Brant-Zawadzk-lumbar disc abnormalities	MR	1995		0.34	60
Mussurakis-breast cancer	MR	1996	0.80	0.58	125
Weishaupt-osteoarthritis	MR	1999		0.42	57
Kurtz-ovarian cancer	MR	1999	0.41	308	
Masdeu-head trauma	SPECT	1994		0.70	179
Wong-early pregnancy complications	US	1998	0.83	0.72	41
Kurtz-ovarian cancer	US	1999	0.85	0.66	151
Ihlberg-vein grafts	US	2000		0.69	264
					69

Psychology Studies

	Field Accuracy Studies							
	Screening				Diagnostic			
	Se	Sp	Total %	Cases	Se	Sp	Total %	Cases
Mean	0.74	0.78	0.76	996	0.72	0.67	0.70	218
Median	0.79	0.85	0.78	307	0.71	0.65	0.69	84
Minimum	0.11	0.00	0.42	55	0.37	0.41	0.50	29
Maximum	1.00	1.00	0.98	16235	0.96	0.95	0.93	1079
Count	36	36	36	36	51	51	51	51

First Author	Year	Se	Sp	Total %	Cases	Se	Sp	Total %	Cases
Bradley-alcohol screening	1998	0.80	0.86	0.83	771				
Bradley-alcohol screening	1998	0.78	0.89	0.83	771				
Brooks-neuropsychological screening	1990	0.80	1.00	0.90	175				
Glascoe-developmental screening	1993	0.72	0.76	0.74	89				
Steer-major depression	1999	0.97	0.99	0.98	120				
Bradley-alcohol screening	1998	0.52	0.85	0.69	771				
Bradley-alcohol screening	1998	0.35	0.98	0.66	771				
Dent-memory problems in multiple sclerosis	2000	0.93	0.48	0.71	61				
Bradley-alcohol screening	1998	0.91	0.77	0.84	771				
Bradley-alcohol screening	1998	0.75	0.89	0.82	771				
Parikh-post-stroke depression	1988	0.86	0.90	0.88	80				
Baird-autism at 18 months of age	2000	0.38	0.98	0.68	16235				
Chen-attention-deficit hyperactivity	1994	0.23	1.00	0.62	122				
Scheinberg-eating disorders	1993	0.93	0.41	0.67	1112				
Scheinberg-eating disorders	1993	1.00	0.38	0.69	1112				
Gureje	1990	0.68	0.70	0.69	787				
Pomeroy-depression	2001	0.91	0.65	0.78	87				
Razavi-adjustment and major depressive disorders	1990	0.70	0.75	0.73	210				
Inwald-performance of government security personnel	1991	0.60	0.76	0.68	307				
Johnson-pathological gamblers	1998	1.00	0.85	0.93	423				
Benussi-alcoholism	1982	1.00	0.94	0.97	104				
Yersin-alcoholism	1989	0.70	0.92	0.81	268				
Erford-Math Essential skills screen	1998	0.98	0.88	0.93	100				
Uhlmann-dementia	1991	0.81	0.97	0.89	209				
Inwald-performance of government security personnel	1991	0.45	0.73	0.59	307				
Colligan-alcoholism	1988	0.74	0.84	0.79	2144				
Colligan-alcoholism	1988	1.00	0.00	0.50	2144				
Colligan-alcoholism	1988	0.62	0.34	0.48	2144				
Hirschfeld-bipolar spectrum disorder	2000	0.73	0.90	0.82	198				
Sherman-Pediatric Language Acquisition	1999	0.11	0.73	0.42	84				
Hiatt-job performance problems	1988	0.68	0.73	0.70	55				
de las Cuevas-Severity of Dependence Scale (SDS)	2000	0.98	0.94	0.96	100				
Birchnell-depressive disorders	1989	0.94	0.86	0.90	133				
Bradley-alcohol screening	1998	0.48	0.86	0.67	771				
Bradley-alcohol screening	1998	0.91	0.72	0.82	771				
Bradley-alcohol screening	1998	0.82	0.85	0.83	771				
Berument-Autism	1999					0.85	0.75	0.80	200
Kogan-Geriatric Depression Scale	1994					0.64	0.73	0.69	59
Laprise- Geriatric Depression	1998					0.96	0.46	0.71	66
Blais-FRANTIC AVOIDANCE	1999					0.63	0.95	0.79	76
Blais-UNSTABLE RELATIONSHIPS	1999					0.94	0.91	0.93	76
Blais-IDENTITY DISTURBANCE	1999					0.73	0.84	0.79	76
Blais-IMPULSIVITY	1999					0.55	0.70	0.63	76
Blais-SUICIDAL	1999					0.96	0.41	0.69	76
Blais-AFFECTIVE INSTABILITY	1999					0.91	0.42	0.67	76
Blais-CHRONIC EMPTINESS	1999					0.52	0.79	0.66	76
Blais-POORLY CONTROLLED ANGER	1999					0.73	0.53	0.63	76
Blais-STRESS-RELATED PARANOIA	1999					0.51	0.60	0.56	76
Kogan-Geriatric Depression Scale	1994					0.79	0.69	0.74	59
Laprise-Geriatric Depression	1998					0.89	0.56	0.73	66
Merson-personality disorders	1994					0.95	0.50	0.73	29
Ivnick-MAYO VERBAL COMPREHENSION FACTOR S	2000					0.55	0.85	0.70	1079
Chaffee-expressive and receptive language scales	1990					0.88	0.45	0.67	152
Ivnick- ATTENTION-CONCENTRATION SCORE	2000					0.71	0.70	0.71	1079
Ivnick-LEARNING FACTOR SCORE	2000					0.77	0.84	0.81	1079
Ivnick-PERCEPTUAL ORGANIZATION SCORE	2000					0.70	0.83	0.77	1079
Ivnick- RETENTION SCORE	2000					0.88	0.80	0.84	1079
BOONE 1994-depression	1994					0.61	0.62	0.62	62
WETZLER 1998-depression	1998					0.64	0.65	0.65	113
BEN-PORATH 1991-depression	1991					0.66	0.64	0.65	73
BEN-PORATH 1991-depression	1991					0.63	0.61	0.62	87
MUNLEY 1997-depression	1997					0.71	0.71	0.71	84
GREENBLATT 1999-depression	1999					0.54	0.56	0.55	75

Psychology Studies

	Field Agreement Studies					
	Screening			Diagnostic		
	Agree %	Kappa	Cases	Agree %	Kappa	Cases
Mean		0.61	510	0.88	0.79	174
Median		0.61	510	0.88	0.79	113
Minimum		0.61	510	0.88	0.64	76
Maximum		0.61	510	0.88	0.91	331
Count	0	1	1	1	6	6

First Author	Year	0.61	510	0.88	0.71	131
Lavigne- DSM-III-R with preschool children	1994					
Klin-autism	2000			0.88	0.72	331
DSM-III Phase Two Field Trials	1980				0.64	331
DSM-III Phase Two Field Trials	1980				0.64	76
Blais-NINE SCALE PERSONALITY DISORDER	1999				0.85	76
Hogervors-Alzheimer's disease	2000				0.90	82
Hilzenroth-Schizophrenia	1998				0.91	95

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